MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05076

CERTIFICATE OF DEATH

05074

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Smithsburg R # 2
   c. LENGTH OF STAY IN 1b: 22 Yrs
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Cavetown-Boonsboro Pike

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Smithsburg R # 2
   d. STREET ADDRESS: Cavetown-Boonsboro Pike
   a. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First JOHN — Middle WESLEY — Last AMBROSE

4. **DATE OF DEATH**: Month April — Day 22 — Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: March 2 1888

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (County & State, or foreign country): Hagerstown Wash Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George L. Ambrose

14. MOTHER'S MAIDEN NAME: Emma Hose

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. (If yes give war or dates of service): -- — SOCIAL SECURITY NO.: 220-34-0904

17. INFORMANT: Mrs Emma E. Ambrose Smithsburg R # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), end (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Vascular Disease — 10 yrs

DUE TO (c): Arterio Sclerosis generalized — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 30, 1962 to April 22 1962 that (I) (we) last saw the deceased alive April 22 1962, and that death occured at 2.35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: G. A. Kohler M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: April 23 1962

22c. PHYSICIAN'S NAME (Type): G. A. KOHLER

22d. ADDRESS: Smithsburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/25/62

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 26 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kuhn

VR A1S (4)
1SM 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05077

CERTIFICATE OF DEATH

05075

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 6 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): JACKSON CONVALESCENT HOME

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 1515 PARK ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BERTHA — Middle: MAE — Last: ANGLE

4. DATE OF DEATH: Month: APRIL — Day: 4 — Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: SEPTEMBER 15 1882

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME MAKER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): FRANKLIN PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: COMMODORE F LOWMAN

14. MOTHER'S MAIDEN NAME: MARGARET YOUNG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: MISS MAE ANGLE HAGERSTOWN MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years
4-50.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20e. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-25-61, 19..., death, 19..., that (I) (we) last saw the deceased alive on 4-1-62 19..., and that death occured at 1:10 AM from the causes and on the date stated above.

22e. SIGNATURE: Paul Harrison (Robert F. Keadle) ----/RFK M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-4-62

22c. PHYSICIAN'S NAME (Type): PAUL HARRISON M. D.

22d. ADDRESS: 318 N POTOMAC ST. HAGERSTOWN MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-6-62

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d. LOCATION (City, town or county) (State): HAGERSTOWN MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Charles M Rouzer

ADDRESS: SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND

25a. REC'D BY REGISTRAR DATE: APR 10 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05078 Item 8 Film G312 5/8/62 iwk 05076

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Md. State Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Md (Old 2-2)
d. STREET ADDRESS: 539 Columbia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CHARLES — Middle Otha — Last BAGENT

4. **DATE OF DEATH**: Month APRIL — Day 29 - — Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 3, 1888 (1887)

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (County & State, or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Jacob H. Bagent

14. MOTHER'S MAIDEN NAME: Anna Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-05-5711

17. INFORMANT — Address: Mrs. Charles O. Bagent Cumb. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Lobular pneumonia	5 days
DUE TO (b)	generalized metastasis	unknown
DUE TO (c)	carcinoma of prostate	3 years

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 4-6-62, 1962, to 4-29, 1962 that (I) (~~me~~) last saw the deceased alive on 4-29-1962, and that death occured at 7:55 M, from the causes and on the date stated above.

22e. SIGNATURE: Victor L. Ramos, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: April 30, 1962

22c. PHYSICIAN'S NAME (Type): VICTOR L. RAMOS, M.D.

22d. ADDRESS: 1500 Pa Ave Hagerstown MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/3/62

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memo. Pk.

23d. LOCATION (City, town or county) (State): Cumberland Md

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Louis Stein Inc. Cumb. Md.

25a. REC'D BY REGISTRAR — DATE: MAY 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05079

CERTIFICATE OF DEATH

05077

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Md. State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hagerstown
d. STREET ADDRESS: Route 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First SUSAN — Middle ----- — Last BARBER

4. **DATE OF DEATH**: Month APRIL — Day 28 — Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 4, 1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Adams Co. Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Leonard Wyssinger

14. MOTHER'S MAIDEN NAME: Mary Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Mrs. Simon Summers — Address: Hag. Rt. 5

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ANEURISM OF THE ABDOMINAL AORTA-RUPTURED — INTERVAL BETWEEN ONSET AND DEATH: FEW HOURS

451 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): GENERALIZED ATHEROSCLEROSIS — UNKNOWN
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
SUBACUTE AND CHRONIC PYELONEPHRITIS

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ____ a.m. p.m. — Month, Day, Year 19__

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 10-19- 19 61, to 4-28 19 62, that (I) (~~we~~) last saw the deceased alive on 4-28- 19 62, and that death occured at 9:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Victoria U. Pallagrosi M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑ — 22b. DATE SIGNED: 5-1-62

22c. PHYSICIAN'S NAME (Type): ANTONIO U. PALLAGROSI

22d. ADDRESS: 1500 Pa Ave Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-1-62

23c. NAME OF CEMETERY OR CREMATORY: Shiloh U. B. Cemetery

23d. LOCATION (City, town or county) (State): Fiddlersburg. Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05080

CERTIFICATE OF DEATH

05078

1. **PLACE OF DEATH**
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEWSVILLE
c. LENGTH OF STAY IN 1b: 18 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NO STREET ADDRESS

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CHEWSVILLE
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First LILLIE — Middle SEIBERT — Last BECK

4. **DATE OF DEATH**: Month APRIL — Day 4 — Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 31 1872

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME MAKER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): FRANKLIN PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CONRAD SEIBERT

14. MOTHER'S MAIDEN NAME: BARBARA FRIESE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. **INFORMANT** — Address: MRS JOHN W CABLE JR CHEWSVILLE MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Arteriosclerotic Cardio Vascular Disease — 10 years

DUE TO

(c):

4-22-1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ — Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-1- 1962, to 4-4- 1962, that (I) (we) last saw the deceased alive on 4-3- 19 62, and that death occured at 3:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: A. W. Ditto M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: APRIL 6 1962

22c. PHYSICIAN'S NAME (Type): E.W.DITTO JR. M. D.

22d. ADDRESS: 215 W WASHINGTON ST. HAGERSTOWN MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-6-62

23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY

23d. LOCATION (City, town or county) (State): HAGERSTOWN MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Charles M Rouzer

ADDRESS: SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND

25a. REC'D BY REGISTRAR — DATE: APR 10 '62

25b. REGISTRAR'S SIGNATURE: Clinton S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05081

CERTIFICATE OF DEATH

05079

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Md. State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Mt. Airy 10X·2
d. STREET ADDRESS: RD#3, Penn Shop Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Arvlee — Middle: — Last: Bridges

4. **DATE OF DEATH**: Month: April — Day: 14 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 27, 1881

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Buildings

11. BIRTHPLACE (County & State, or foreign country): Campbell Co., Tenn.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William H. Bridges

14. MOTHER'S MAIDEN NAME: Catherine Foust

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-16-1484

17. INFORMANT — Address: Mr. Ollie Bridges, New Market, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Lobular Pneumonia, bilateral	3 days
DUE TO (b)	cerebro-vascular Accident	3 years
DUE TO (c)	general arteriosclerosis	20 years

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from April 6, 1962 to April 14, 1962 that (I) (~~we~~) last saw the deceased alive on April 14, 1962, and that death occured at 9:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: April 14, 1962

22c. PHYSICIAN'S NAME (Type): Victor L. Ramos, M.D.

22d. ADDRESS: Western Md. State Hospital Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/17/62

23c. NAME OF CEMETERY OR CREMATORY: Montgomery Meth.

23d. LOCATION (City, town or county) (State): Clagettsville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molsworth

ADDRESS: Damascus, Md.

25a. REC'D BY REGISTRAR DATE: APR 18 '62

25b. REGISTRAR'S SIGNATURE: Clifford L. Krause

1

FOR STATE HEALTH DEPT.

IMPORTANT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05082

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05080

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 57 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 13 Hagerstown
d. STREET ADDRESS: 27 N. Locust
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Clayton — Last: Carper

4. DATE OF DEATH: Month: April — Day: 14 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 29, 1897

9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Retail Store

11. BIRTHPLACE (State or foreign country): White Post, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Carper

14. MOTHER'S MAIDEN NAME: Elizabeth Grubbs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-09-0805

17. INFORMANT — Address: Mrs. Dorothea C. Carper Hag. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Recent
DUE TO (b): Pulmonary Congestion & Edema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 434.4
DUE TO (c): Coronary Atherosclerosis, Severe
(c): Cardiac Hypertrophy

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: April 14, 1962

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-16-62

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or country) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR — ADDRESS: Scott F. Minnich & Son Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: APR 17 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05083

CERTIFICATE OF DEATH

05081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 4 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
   d. STREET ADDRESS: 357 Ridge Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: GEORGE — Middle: ELVIN — Last: CONDON

4. **DATE OF DEATH**: Month: April — Day: 23 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 25 1898

9. AGE (In years last birthday): 63 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (City & State or Foreign country): Franklin Co Green Stone Penna

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Condon

14. MOTHER'S MAIDEN NAME: Nora Sease

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 705-10-5886

17. **INFORMANT**: Mrs Pauline V. Condon 357 Ridge Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Lymphocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

204.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ① Epidermal Cancer ② general arteriosclerosis - ③ prostate hypertrophy, Benign

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 28, 1960 to Apr 23, 1962 that (I) (we) last saw the deceased alive on Apr 22 1962 and that death occured at 5:52 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward W. Ditto III M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Edward W. Ditto 111, M.D.

22d. ADDRESS: 217 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/26/62

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 26 '62

25b. REGISTRAR'S SIGNATURE: Carlton S. Krause

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05084 05082

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased livad, If Institution: Residence before edmission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X(Rural) Hagerstown RFD #3
d. STREET ADDRESS: Sharpsburg Pike
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary — Middle Hetzer — Last Downey

4. DATE OF DEATH: Month April — Day 30 — Year 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 2 1885

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months 8 Days 27 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Park Head Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Charles Hetzer

14. MOTHER'S MAIDEN NAME: Anna Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or detes of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Sharpsburg Pike Mr. George B. Downey Hagerstown RFD 3 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Traumatic Ruptures,(Two) First Part Of Jejunum
816X
DUE TO (b): Acute Generalized Peritonitis
Conditions, if any, which gave rise to Immediate cause (a), steting the underlying cause lest.
DUE TO (c): Multiple Bony Fractures: Left Ilium Right Patella

INTERVAL BETWEEN ONSET AND DEATH: 36 Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Incollision with another car Sharpsburg Pike 1 mile South Of

20c. TIME OF INJURY Hour 7:30 p.m. Month, Day, Year 4-28-62 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Sharpsburg Pike

20f. (City or town): Hagerstown, Washington, Md. (County) Hagerstown.

21. I certify that I took charge of the remains described above, held en Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: A. W. Ditto Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county)

DATE SIGNED: May 1, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 2-62

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or country) (State): Hagerstown Md.

23. FUNERAL DIRECTOR: Albert L Leaf

ADDRESS: Williamsport, Md

24a. REC'D BY REGISTRAR DATE: MAY 3 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO DELIVERY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05085

CERTIFICATE OF DEATH

05083

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Marbern Road

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — WASHINGTON
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: Marbern Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROY — Middle MADISON — Last EASTERDAY

4. DATE OF DEATH: Month April — Day 29 — Year 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: September 30, 1876

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: self emplyed

11. BIRTHPLACE (County & State, or foreign country): Frederick Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Martin V. Easterday

14. MOTHER'S MAIDEN NAME: Susan Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-09-3826

17. INFORMANT: Mrs. Margaret Ruth, Address Marbern Road, Hagerstown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 2 months

692.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Abscesses, multiple, right leg — 2 months.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease, cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-24-62, 19..., to death, 19..., that (I) (we) last saw the deceased alive on 4-28-62, and that death occured at 6:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert F. Keadle M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-30-62

22c. PHYSICIAN'S NAME (Type): Robert F. Keadle

22d. ADDRESS: 318 North Potomac Street, Hagerstown

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 1, 1962

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven

23d. LOCATION (City, town or county) (State): Hagerstown Wash. Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Paul F. Bittle, Myersville, Md.

25a. REC'D BY REGISTRAR DATE: MAY 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05086

CERTIFICATE OF DEATH

05084

DR LIE VAIN

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROHRERSVILLE
c. LENGTH OF STAY IN 1b: 75 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MAIN ST.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ROHRERSVILLE
d. STREET ADDRESS: MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALBERTA — Middle — Last EASTON

4. DATE OF DEATH: Month APRIL — Day 4 — Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: FEBRUARY 9 1877

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months 1 Days 25 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): PARK HALL WASH. Co. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOHN REEDER

14. MOTHER'S MAIDEN NAME: MALINDA DICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: MRS. GROVER DORMAN HAGERSTOWN MD. R. 3

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
450.0
DUE TO (b): Fracture of right hip — 1 week
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 10, 1961, to 4-4, 1962, that (I) (we) last saw the deceased alive on 4-7 1962, and that death occured at 11 P.M. from the causes and on the date stated above.

22a. SIGNATURE: G.W. Leedan M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/6/62

22c. PHYSICIAN'S NAME (Type): G.W. Leedan

22d. ADDRESS: Boonsboro, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: APRIL-7-1962

23c. NAME OF CEMETERY OR CREMATORY: ROHRERSVILLE CEMETERY

23d. LOCATION (City, town or county) (State): ROHRERSVILLE WASH. Co. MD.

24 FUNERAL DIRECTOR'S SIGNATURE: John H. Bast — **ADDRESS**: BOONSBORO MD.

25a. REC'D BY REGISTRAR DATE APR 11 '62

25b. REGISTRAR'S SIGNATURE: Clifford L. Keefer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

1

FOR STATE HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05085

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 640 Summit Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 640 Summit Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lewis — Middle: Markell — Last: Eberly

4. DATE OF DEATH: Month: April — Day: 29 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 16, 1962

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months: 2 Days: 13 — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Frank Eberly

14. MOTHER'S MAIDEN NAME: Norma Jean Neff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No.

16. SOCIAL SECURITY NO.: ----

17. INFORMANT — Address: Frank Eberly Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): INTERSTITIAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: Recent

571.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Pulmonary congestion and edema

DUE TO (c): Gastro-enteritis, nonspecific

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

2De. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto Jr M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): E. W. DITTO, JR., M. D.

Address (Street, city, town, or county):

DATE SIGNED: 4-30-62

2

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-30-62

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or country) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR — ADDRESS: Scott F. Minnich & Son Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAY 2 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

2-002509

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05088

CERTIFICATE OF DEATH

Reg. Dist. No. 05086

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 20 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: FREDERICK ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MYERSVILLE 10x-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RICHARD — Middle E. — Last FRANKLIN

4. DATE OF DEATH: Month 4 — Day 1 — Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/17/1884

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?

10b. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): WASHINGTON COUNTY, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles F. Downs

14. MOTHER'S MAIDEN NAME: Anna R. Pierce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: HOWARD L. DOWNES — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): NEPHROSCHLEROSIS WITH UREMIA — INTERVAL BETWEEN ONSET AND DEATH: MO.
DUE TO (b): GENERALIZED ARTERIOSCHLEROSIS — YR.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4-46 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NO

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/12, 19 62, to 4/1, 19 62, that I last saw the deceased alive on 4/1, 19 62, and that death occurred at 4:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Jacob G. Warden, M.D. — ADDRESS (Street, city or town, state): 832 POTOMAC AVE. — DATE SIGNED

PHYSICIAN'S NAME (Type): JACOB G. WARDEN, M.D. — HAGERSTOWN, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/ /62
22c. NAME OF CEMETERY OR CREMATORY: Grantsville Cem.
22d. LOCATION (City, town, or county) (State): Grantsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A. P. Konhaus — ADDRESS: Meyersdale, Pa

24a. REC'D BY REGISTRAR DATE: APR 9 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Thuma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05088 — 05087

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 10 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Homewood Church Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
e. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1 21 East Antietam Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First LAURA — Middle ELLEN — Last FUNK

4. **DATE OF DEATH**: Month April — Dey 24, — Year 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 16, 1866

9. AGE (In years last birthday): 96 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): St. James Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Solomon Funk

14. MOTHER'S MAIDEN NAME: Catherine Rowland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Homewood Church Home Records, Williamsport, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemmhage
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c): General arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X

INTERVAL BETWEEN ONSET AND DEATH: (a) 1 hr. (b) Yes (c) Yes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Yeer: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug, 1960 to 4/24, 1962, that (I) (---) last saw the deceased alive on 4/21, 19 62, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Louis L Graff, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/25/62

22c. PHYSICIAN'S NAME (Type): Louis L GRAFF

22d. ADDRESS: 119 E. Antietam Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/26/62

23c. NAME OF CEMETERY OR CREMATORY: Zion E&R Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Maryland.

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Andrew K. Coffman, Hagerstown, Maryland

25a. REC'D BY REGISTRAR DATE: APR 26 '62

25b. REGISTRAR'S SIGNATURE: Cathryn L. Kinnis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05090

CERTIFICATE OF DEATH

05088

M

91

I

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland b. COUNTY: Charles
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Point
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

08X-2

3. NAME OF DECEASED (Type or print) First: Joseph Middle: Richard Last: GOOSEBERRY

4. DATE OF DEATH Month: 4 Day: 20 Year: 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 1, 1904

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oysterman (Waterman)

10b. KIND OF BUSINESS OR INDUSTRY: Oyster Business

11. BIRTHPLACE (County & State, or foreign country): Charles County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Goosberry

14. MOTHER'S MAIDEN NAME: Mary Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Non

16. SOCIAL SECURITY NO.: 213-16-2823

17. INFORMANT / Address: Mrs. Margaret E. Goosberry-Wife-Rock Point, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of esophagus — INTERVAL BETWEEN ONSET AND DEATH: one year 4 months

150X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 29, 1962 to April 20, 1962 that (I) ~~(we)~~ last saw the deceased alive on April 20, 1962 and that death occured at 8:02 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Young E. Chun M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 4/20/1962

22c. PHYSICIAN'S NAME (Type): YOUNG E CHUN

22d. ADDRESS: 1500 Penna Ave Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/24/1962

23c. NAME OF CEMETERY OR CREMATORY: Holy Ghost Cemetery

23d. LOCATION (City, town or county) (State): Issue, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Arehart Funeral Home, Inc. — ADDRESS

Arehart Funeral Home, Inc. - La Plata, Md.

25a. REC'D BY REGISTRAR DATE: APR 25 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 7/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05091

CERTIFICATE OF DEATH

05089

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1 (M) (I)

R. LEVAN Rx

1. PLACE OF DEATH a. COUNTY: WASHINGTON	**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EAKLES MILL c. LENGTH OF STAY IN 1b: 10 YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EAKLES MILL - RURAL
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KEEDYSVILLE MD. R.1	d. STREET ADDRESS: KEEDYSVILLE MD. R.1. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ADAM	E.	GREEN	APRIL	14	1962

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE		JANUARY 2 1892	70 yrs.	3 / 12	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED FARM LABORER		MYERSVILLE FRED. CO. MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
SAMUEL GREEN	MARGARET HOLMES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO.	215-18-1072	MRS. LULA S. GREEN KEEDYSVILLE MD. R.1

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Headach — INTERVAL BETWEEN ONSET AND DEATH: yrs

DUE TO (b): decompensation — 1 hour

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov 10, 1961, to April 14, 1962, that (I) (we) last saw the deceased alive on April 11, 1962, and that death occured at 5 P.M., from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
G.W. Ledan			4/16/62
22c. PHYSICIAN'S NAME (Type) G. W. Ledan		**22d. ADDRESS** Boonsboro	Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	APRIL 17, 1962	MT. LENA CEMETERY	MT. LEA WASH. CO. MD.

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John H. Bast	BOONSBORO MD	APR 23 '62	Esther S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05092

CERTIFICATE OF DEATH

05090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 5 months
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Western Maryland State Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 1 Hagerstown
   d. STREET ADDRESS: 1019 Corbett St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Jesse — Middle: FRANKlin — Last: Greene

4. **DATE OF DEATH**: Month: April — Day: 1 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 28, 1885

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Hag. Gas Co.

11. BIRTHPLACE (County & State, or foreign country): Martinsburg, W. Va Berkly. Sp

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Martin Greene

14. MOTHER'S MAIDEN NAME: Susan Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: 317-09-3691A

17. INFORMANT: Mrs. Virginia Corsi — Address: 401. S. Potomac St.

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e): Lobular pneumonia, bil. — INTERVAL BETWEEN ONSET AND DEATH: 5 days

331 X

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO (b): cerebro-vascular accident — 9 days

DUE TO (c): generalized arteriosclerosis — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): (1) cerebro-vascular accident, old c hemiparesis (2) Hypertensive cardio-vascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from October 19, 1961, to April 1, 1962, that (I) ~~(we)~~ last saw the deceased alive on April 1, 1962, and that death occured at 12:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: April 1, 1962

22c. PHYSICIAN'S NAME (Type): VICTOR L. Ramos, M.D

22d. ADDRESS: Western Md. State Hospital Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/4/62

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

(M)

(1)

1

FOR STATE HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05093 05091

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mohtgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Maryland 1524.2
d. STREET ADDRESS: 413 Mansfield Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JONATHAN Middle B. Last GRONER

4. DATE OF DEATH: Month April Day 29, Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 26, 1947

9. AGE (In years last birthday): 15 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel B. Groner

14. MOTHER'S MAIDEN NAME: Molly Wexler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No -

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Molly W. Groner 413 Mansfield Rd., SSpg, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 816 X — SHOCK DUE TO MASSIVE BRAIN DAMAGE
DUE TO (b): FRACTURED RIBS-FRACTURED LEFT ARM & LEFT LEG.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 24 HOURS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PATIENT DIED ENROUTE BY AMBULANCE ON WAY TO CHILDREN'S HOSP. WASHINGTON, D.C.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II, as appropriate.): STRUCK HEADON BY CAR COMMING IN OPPOSITE DIRECTION.

20c. TIME OF INJURY Hour XX p.m. Month, Day, Year: 5:00 4-28 19 62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RT.#40, GRANTSVILLE, MD.

20f. (City or town) (County) (State): 3/4 OF MILE FROM GRANTSVILLE, HAGERSTOWN WASH. MD. MI

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: N. W. Ditto Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED:

EXAMINER'S NAME (Type): DR. E.W.DITTO, JR.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 1, 1962

22c. NAME OF CEMETERY OR CREMATORY: National Memorial Park

22d. LOCATION (City, town, or country) (State): Falls Church, Va.

23. FUNERAL DIRECTOR: Goodley Funeral Home ADDRESS: 4217 9th Street N.W.

24a. REC'D BY REGISTRAR DATE: 4-29-62 MAY 3 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05094

CERTIFICATE OF DEATH

05092

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 26 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1241 Potomac Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Anthea — Middle: Ruth — Last: Hankey

4. DATE OF DEATH: Month, Day, Year: April 14, 1962

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 10, 1917

9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): assembler

10b. KIND OF BUSINESS OR INDUSTRY: aircraft mfg.

11. BIRTHPLACE (County & State, or foreign country): Somerset, Penna.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ira R. Barron

14. MOTHER'S MAIDEN NAME: Anna Baltzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-09-8783

17. INFORMANT Address: Wm. L. Hankey, Jr., Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic pyleonephritis
DUE TO (c): Cardiac Hypertension
R. L.L. Pneumonia

443X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: none 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) - (County) - (State) -

21. I certify that (I) (this hospital) attended the deceased from July, 1961, to Apr. 14, 1962, that (I) (we) last saw the deceased alive on Apr. 14 1962, and that death occured at P.M, from the causes and on the date stated above.

22a. SIGNATURE: Harold R. Tritch Jr M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-16-62

22c. PHYSICIAN'S NAME (Type): Harold R. Tritch, Jr. MD

22d. ADDRESS: 302 N. Potomac St-Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 4-17-62

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 18 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05093

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural) Sharpsburg
   c. LENGTH OF STAY IN 1b: 10 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sharpsburg On RFD #34

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sharpsburg
   d. STREET ADDRESS: Sharpsburg RFD #1
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Donald — Middle: Alvin — Last: Helman Jr.

4. **DATE OF DEATH**: Month: April — Day: 8 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 8 1942

9. AGE (In years last birthday): 19 yrs. — IF UNDER 1 YEAR: Months 4 Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attendant

10b. KIND OF BUSINESS OR INDUSTRY: Filling Station

11. BIRTHPLACE (State or foreign country): Mercersburg Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Donald Alvin Helman Sr.

14. MOTHER'S MAIDEN NAME: Anna Virginia Yeager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-42-3778

17. INFORMANT: Mr. J. Edgar Churchey — Address: Sharpsburg RFD #1 Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Struck abutment of underpass R# 34, 2 mile West of Sharpsburg, Md.

20c. TIME OF INJURY: Hour 2:30 p.m. — Month, Day, Year: 4-8- 1962

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): State R # 34

20f. (City or town) (County) (State): Sharpsburg, Washington, Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ACTUAL SIGNATURE: E. W. Ditto M.D.

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county):

DATE SIGNED: 4-9-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 11-62

22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

22d. LOCATION (City, town, or country) (State): Sharpsburg Maryland

23. FUNERAL DIRECTOR: Albert L. Leaf — ADDRESS: Williamsport, Md

24a. REC'D BY REGISTRAR DATE: APR 12 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05096

CERTIFICATE OF DEATH

05094

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
   c. LENGTH OF STAY IN 1b: 3 WEEKS
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WASH. Co. HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
   d. STREET ADDRESS: 22 SOUTH POTOMAC ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

DR. JACK BEACHLEY 221 W. WASH. ST.

3. **NAME OF DECEASED** (Type or print): First GRACE — Middle LINNIE — Last HELSER

4. **DATE OF DEATH**: Month APRIL — Day 27 — Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 11 1901

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months 1 — Days 16 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WAITRESS

10b. KIND OF BUSINESS OR INDUSTRY: DEVON HOTEL

11. BIRTHPLACE (County & State, or foreign country): OAK GROVE PENNA. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ABRAHAM HELSER

14. MOTHER'S MAIDEN NAME: ADDIE DALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 220-16-3741

17. INFORMANT: MRS. LEROY HARTRANFT — Address: 523 SALEM AVE, HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis.

INTERVAL BETWEEN ONSET AND DEATH: 3 Wks

DUE TO (b): 420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/2/62 to 3/27/62, that (I) (we) last saw the deceased alive on 3/26/62, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: J M Beachley M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/1/62

22c. PHYSICIAN'S NAME (Type): J M Beachley

22d. ADDRESS: Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 1. 1962

23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEMETERY

23d. LOCATION (City, town or county) (State): KEEDYSVILLE WASH. Co. MD

24. FUNERAL DIRECTOR'S SIGNATURE: John W. Bast — ADDRESS: BOONSBORO MD.

25a. REC'D BY REGISTRAR DATE: MAY 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

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Form may be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05097? 05095

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospiital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
   d. STREET ADDRESS: 509 Beverly Lane
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Linda — Middle: Sue — Last: Hemphill

4. **DATE OF DEATH**: Month: April — Day: 14 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 3, 1961

9. AGE (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Hemphill

14. MOTHER'S MAIDEN NAME: Esther G. Sheasley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. Geo. W. Hemphill 509 Beverly Lane Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cradiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Post surgical correction of Malrotation of intestine — 4 days.

DUE TO (c): & marked adhesions

756.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/9, 19 62 to 1/14, 19 62 that (I) (we) last saw the deceased alive on 1/14, 19 62 and that death occured at 1:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Richard A. Young M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4/16/62

22c. PHYSICIAN'S NAME (Type): Richard A. Young — 22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/16/62 — 23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery — 23d. LOCATION (City, town or county) (State): Hagerstown Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown, Md. — 25a. REC'D BY REGISTRAR DATE APR 17 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Wm. A. Horst

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05098 05096

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2½ wks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greencastle
d. STREET ADDRESS: 148 N. Carlisle St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Edith — Last: Henson

4. DATE OF DEATH: Month: April — Day: 30 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 28, 1887

9. AGE (If years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Housekeeping

11. BIRTHPLACE (State or foreign country): Washington Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Henry Lum

14. MOTHER'S MAIDEN NAME: Sarah Atherton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Kenneth N. Henson — Address: Greencastle, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 18 days
DUE TO
(b): Arteriosclerotic Cardio-Vascular
DUE TO
(c): disease — 15 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse lost. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 4/12, 1962, to 4/30, 1962 that (I) (~~we~~) last saw the deceased alive on 4/30/62, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. G. Brewer M.D. — 22b. DATE SIGNED: (5:30) P.M.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): W. G. Brewer, M.D.

22d. ADDRESS: Greencastle, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-3-1962

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Harold M. Zimmerman — ADDRESS: Greencastle, Pa

25a. REC'D BY REGISTRAR DATE: MAY 7 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05099

CERTIFICATE OF DEATH

05097

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: life
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Coun;ty Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Wash.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
   d. STREET ADDRESS: 551 W. Howard St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Waldo — Middle: Emerson — Last: Hill

4. **DATE OF DEATH**: Month: April — Day: 7, — Year: 19 62

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1894

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): car inspector

10b. KIND OF BUSINESS OR INDUSTRY: railroad

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David E. Hill

14. MOTHER'S MAIDEN NAME: Ida F. Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Beulah M. Hill, Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Instant
DUE TO (b)	Hypertensive Cardio Vascular Disease	15 months
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-1- , 1962., to 4-7- , 19 62 that (I) (we) last saw the deceased alive on 4-7- 19 62., and that death occured at 6:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: J. W. Ditto M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-9-62

22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr.

22d. ADDRESS: 215 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: Apr. 10,62

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

25a. REC'D BY REGISTRAR — DATE: APR 11 '62

25b. REGISTRAR'S SIGNATURE: Catherine S. Thomas

1

FOR STATE HEALTH DEPT.

(M)

TO DELIVERY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit; file pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05100 05098

Item #3, FilmG312-5/11/62-mmb

1. PLACE OF DEATH
   a. COUNTY: WASHINGTON
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ENROUTE TO HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - EAKLES MILL
   d. STREET ADDRESS: KEEDYSVILLE MD. R.1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JESSIE Middle WEATHER CLAY Last HOLMES

4. DATE OF DEATH: Month APRIL Day 6 Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 30 1889

9. AGE (In years last birthday): 72 yrs.
   IF UNDER 1 YEAR: Months 11 Days 6
   IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED EMPLOYEE

10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R. Co

11. BIRTHPLACE (State or foreign country): NR. KEEDYSVILLE WASH. Co. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: NELSON ~~OWEN~~ HOLMES

14. MOTHER'S MAIDEN NAME: SUSAN SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
   (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS. MARY DITTO Address: HAGERSTOWN MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed Chest — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

8.16X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Car he was driving ran into rear of car he was following.

20c. TIME OF INJURY: Hour 8 a.m. Month, Day, Year 4-6-1962

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): R# 40 A.

20f. (City or town) Boonsboro, (County) Washington, (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF M.D.: L. Henry Wyles

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4-7-62

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: APRIL-9-1962

22c. NAME OF CEMETERY OR CREMATORY: LOCUST GROVE CEMETERY

22d. LOCATION (City, or town, country) (State): LOCUST GROVE WASH. Co. MD

23. FUNERAL DIRECTOR: John H. Bost ADDRESS: BOONSBORO MD

24a. REC'D BY REGISTRAR DATE: APR 11 '62

24b. REGISTRAR'S SIGNATURE: Clinton L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05101

CERTIFICATE OF DEATH

Reg. Dist. No. 05099

1. PLACE OF DEATH
a. COUNTY Wash. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Pa. b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Greencastle 75x3
d. STREET ADDRESS RD1 - Greencastle, Pa.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MICHAEL Middle L. Last HORSH
4. DATE OF DEATH: Month 4 Day 25 Year 1962
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/26/1884
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance
10b. KIND OF BUSINESS OR INDUSTRY: Landis Tool Co.
11. BIRTHPLACE (State or foreign country): Opton, PA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abraham Horsh
14. MOTHER'S MAIDEN NAME: Mary E. Sheeley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 204-03-5672
17. INFORMANT: Estella C. Horsh Address: RD1 Greencastle Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis (arteriosclerotic) DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Myocardial infarction syndrome DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: (a) immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary Tuberculosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1955, to Apr. 25, 1962, that I last saw the deceased alive on Apr. 25, 1962, and that death occurred at 5:55 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE W. C. Brauer M.D. ADDRESS (Street, city or town, state) Greencastle, Pa. DATE SIGNED
PHYSICIAN'S NAME (Type) W. C. Brauer Greencastle, Pa.

22a. BURIAL, CREMATION, REMOVAL (Specify) B
22b. DATE THEREOF 4/28/62
22c. NAME OF CEMETERY OR CREMATORY Upton Brethren Cem.
22d. LOCATION (City, town, or county) (State) Upton, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE A. E. Mummert ADDRESS Greencastle, Pa.
24a. REC'D BY REGISTRAR DATE APR 30 '62
24b. REGISTRAR'S SIGNATURE Arthur S. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05102

CERTIFICATE OF DEATH

05100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 1 Day
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
   d. STREET ADDRESS: 1707 Sherman Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: WILLIAM — Middle: HENRY — Last: HUFF

4. **DATE OF DEATH**: Month: April — Day: 6 — Year: 1962 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 16 1883

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lineman -Retired

10b. KIND OF BUSINESS OR INDUSTRY: C&P Tel. Co

11. BIRTHPLACE (County & State or foreign country): Leetown Jefferson Co W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Noah Huff

14. MOTHER'S MAIDEN NAME: Ella Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: 212-05-0839

17. INFORMANT: Mrs Ola D. Huff 1707 Sherman Ave Hagerstown Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronal pulmonale
DUE TO (b): Emphysema
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): arteriosclerosis & myhroscleroses

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/7/ 19 62 to 4/6 19 62 that (I) (we) last saw the deceased alive on 4/6 1962, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Howard N. Weeks M.D. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/6/62

22c. PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D.

22d. ADDRESS: 136 N. Potomac Street

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/9/62

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 10 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05103 Reg. Dist. No. 05101

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Big Spring
c. LENGTH OF STAY IN 1b 4 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION R.D.1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Penna b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mercersburg, Pa.
d. STREET ADDRESS R. D. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First William Middle H. Lost Hunsberger

4. DATE OF DEATH Month Apr. Day 13, Year 1962

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 10/8/1875
9. AGE (In years last birthday) 86 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER
10b. KIND OF BUSINESS OR INDUSTRY RELIGION
11. BIRTHPLACE (State or foreign country) Washington Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME David Hunsberger
14. MOTHER'S MAIDEN NAME Jane Ringer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT C. W. Hunsberger, Address Mercersburg, Pa., R. 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Dis — INTERVAL BETWEEN ONSET AND DEATH 10 yrs
4-20-0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 17, 1955 to Apr 13, 1962 that I last saw the deceased alive on Apr 10, 1962, and that death occurred at 1:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE David R. Brewer M.D. ADDRESS (Street, city or town, state) Clear Spring Md DATE SIGNED 4/13/62

PHYSICIAN'S NAME (Type) David R. Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 4/15/62
22c. NAME OF CEMETERY OR CREMATORY Broadfording Cem.
22d. LOCATION (City, town, or county) (State) Washington Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE Ellis Zeiger ADDRESS Mercersburg, Pa.
24a. REC'D BY REGISTRAR DATE APR 16 '62
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05104

CERTIFICATE OF DEATH

05102

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sharpsburg
   d. STREET ADDRESS: 138 W. Main Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Cora — Middle: Lucinda — Last: Hutson

4. **DATE OF DEATH**: Month: April — Day: 30 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 26 1882

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months: 2 Days: 3 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: James Pierce

14. MOTHER'S MAIDEN NAME: Amanda Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mrs. Mae Hebb Sharpsburg Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive heart failure	1 week.
DUE TO (b)	Arteriosclerotic cardio-vascular diseae	5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Arteriolar-nephro-sclerosis	1 year.

442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1956, 19..., to May 1, 1962, that (I) (we) last saw the deceased alive on May 1 1962, and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: Walter H. Shealy M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 2, 1962.

22c. PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22d. ADDRESS: Sharpsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 3-62

23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

23d. LOCATION (City, town or county) (State): Sharpsburg Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf — ADDRESS: Williamsport, Maryland

25a. REC'D BY REGISTRAR DATE MAY 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05105

CERTIFICATE OF DEATH

05103

1

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

M

X

I

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 9 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 121 East Franklin Street

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 13 Hagerstown
   d. STREET ADDRESS: 121 East Franklin Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: MARY — Middle: DELOSIER — Last: JACKSON

4. **DATE OF DEATH**: Month: April — Day: 17, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 10, 1882.

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Maryland.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: James K. Delosier

14. MOTHER'S MAIDEN NAME: Lydia Clevidence

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: 215-34-3897

17. **INFORMANT**: Mrs. Bertha M. Bergum, 124 Randolph Ave. — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostasis and atherosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO (b): Osteoarthritis — 4 years.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 11, 19 62, to April 17, 19 62, that (I) (we) last saw the deceased alive on April 10 19 62, and that death occured at 5 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John J. Hyleman M.D.

22c. PHYSICIAN'S NAME (Type)

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS

22b. DATE SIGNED: 4/12/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/19/62

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Maryland.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Maryland.

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kruss

1 (M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05106

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05104

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clubhouse 3mi. South Of Sharpsburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): State R#34

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1 27 Wayside Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ralph — Middle: Frederick — Last: Keplinger Sr.

4. DATE OF DEATH: Month: April — Day: 30 — Year: 1962

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married [X]	Aug. 4, 1897	64 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner	Shoe repair shop	Wash. Co. Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Keplinger	Anna Mull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	W. W. 1	214-09-5418	Mrs. Grace Keplinger	Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxiation Carbon Monoxide — INTERVAL BETWEEN ONSET AND DEATH: Recent
973.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Connected hose from exhaust pipe inserted into closed car.

20c. TIME OF INJURY: Hour a.m.	Month, Day, Year	20d. INJURY OCCURRED: While at work ☐ Not While at work [X]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
11	4-30- 1962		State R # 34	Sharpsburg, Washington, Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection [X], Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide [X], Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: A. W. Ditto Jr. M.D.
EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: May 2, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	5-3-62	Rose Hill Cemetery	Hagerstown, Md.

23. FUNERAL DIRECTOR — ADDRESS	24a. REC'D BY REGISTRAR — DATE	24b. REGISTRAR'S SIGNATURE
Scott F. Minnich & Son Hagerstown, Md.	MAY 4 '62	Arthur L. Kraus

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05107

CERTIFICATE OF DEATH

05105

TO FUNERAL DIRECTOR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON CONTY HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
   d. STREET ADDRESS: 309 S. POTOMAC ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: TODD — Middle: DWAYNE — Last: KESSELRING

4. **DATE OF DEATH**: Month: ARRIL — Day: 12 — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/12/1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours: 2 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DONALD LOWELL KESSELRING

14. MOTHER'S MAIDEN NAME: ANNA DAYMUDE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MR. DONALD L. KESSELRING — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hydrops Fetalis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: none 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town): - (County): - (State): -

21. **I certify** that (I) (this hospital) attended the deceased from Apr. 12, 1962, to Apr. 12, 1962, that (I) (we) last saw the deceased alive on Apr. 12 19 62, and that death occured at 10 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Harold R Tritch Jr M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-13-62

22c. PHYSICIAN'S NAME (Type): Harold R. Tritch, Jr. MD

22d. ADDRESS: 302 N. Potomac St Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/13/62

23c. NAME OF CEMETERY OR CREMATORY: CEDAR LAWN MEM. GARDENS

23d. LOCATION (City, town or county) (State): HAGERSTOWN MD.

24 FUNERAL DIRECTOR'S SIGNATURE: W. J. Rosmeat, Hagerstown, Md.

ADDRESS:

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2-060443

VR A1S (4)
1SM 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05108

CERTIFICATE OF DEATH

05106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

91

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2

1

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 6 Months
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Western Maryland State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland — b. COUNTY: ~~Garrett~~ Allegany ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 0102-2
   d. STREET ADDRESS: 227 Springdale Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Clara — Middle: A. — Last: KIMMELL

4. **DATE OF DEATH**: Month: 4 — Day: 4 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 4, 1884

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Garrett, Somerset Co. Pa.

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Kaiser Kimmel

14. MOTHER'S MAIDEN NAME: Emma Wooley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Toledo, Ohio — Mrs. Mary Vaillant 4055 Walker Ave.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): LOBULAR PNEUMONIA BILATERAL — INTERVAL BETWEEN ONSET AND DEATH: 5-DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CEREBRAL THROMBOSIS — 9-MONTHS

DUE TO (c): GENERALIZED ARTERIOSCLEROSIS — UNKNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ACUTE & CHRONIC PYELONEPHRITIS - DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ✓ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Yaer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 16, 1961 to April 4, 1962 that (I) (~~was~~) last saw the deceased alive on April 4 1962, and that death occured at 5:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Antonio U. Pallagrosi M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 4-5-62

22c. PHYSICIAN'S NAME (Type): ANTONIO U. PALLAGROSI

22d. ADDRESS: 1500 Penna. Ave. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/7/62 — 23c. NAME OF CEMETERY OR CREMATORY: Toledo Memorial Cemetery, Sylvania, Ohio — 23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Andrew K. Coffman Hagerstown, Maryland.

25a. REC'D BY REGISTRAR: DATE APR 9 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

VR A1S (4)
1SM 7/61

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05109 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05107

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 9/60

1. PLACE OF DEATH
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
   d. STREET ADDRESS: 443 N. Prospect St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Douglas — Middle: Lee — Last: Kunkle

4. DATE OF DEATH: Month: April — Day: 2 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 4, 1942

9. AGE (In years last birthday): 19 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jack U. Kunkle

14. MOTHER'S MAIDEN NAME: Lillian J. Walden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. J. U. Kunkle 443 N. Prospect St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	3 months
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Cerebral Lacerations	3 months
DUE TO (c)	Gastric Ulcer With Hemorrhage	
	Pneumonitis	Recent

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.): In Auto accident on R# 40 A. 5 mi. East of Hagerstown, Md.

20c. TIME OF INJURY — Hour a.m. 4 — Month, Day, Year: 12-31- 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 40 A.

20f. (City or town) Hagerstown, (County) Washington, (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4-3-62

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/5/62

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or country): Hagerstown (State) Md.

23. FUNERAL DIRECTOR: Rest Haven Funeral Chapel — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: APR 5 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Haver

Wm. C. Host

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05110

CERTIFICATE OF DEATH

05108

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
   c. LENGTH OF STAY IN 1b: ONE MONTH
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 214 NORTH POTOMAC ST.

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: DISTRICT OF COLUMBIA.
   b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
   d. STREET ADDRESS: 2123 EYE ST. N.W.
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. **NAME OF DECEASED** (Type or print): First BLANCHE Middle B. Last LAMAR

4. **DATE OF DEATH**: Month APRIL Day 20 Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE-30-1895

9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months 9 Days 20 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SECRETARY

10b. KIND OF BUSINESS OR INDUSTRY: U.S. SENATOR

11. BIRTHPLACE (County & State, or foreign country): BOONSBORO WASH. CO. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ROBERT F. LAMAR

14. MOTHER'S MAIDEN NAME: NELLIE EAKLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO.

16. SOCIAL SECURITY NO.: 577-56-9651

17. INFORMANT: MRS. ROSS BOWARD Address: 214 N. POTOMAC ST. HAGERSTOWN MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: MINUTES

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE — UNKNOWN

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 26 MARCH, 1962, to 20 APRIL, 1962, that (I) (we) last saw the deceased alive on 20 APRIL 1962., and that death occured at 5:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: D. Q. Lowden M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 20 APRIL 1962

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: APRIL 23, 1962

23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

23d. LOCATION (City, town or county) (State): BOONSBORO WASH. CO. MD.

24 FUNERAL DIRECTOR'S SIGNATURE: John W. Bast ADDRESS: BOONSBORO MD.

25a. REC'D BY REGISTRAR DATE: APR 25 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kreis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05111

CERTIFICATE OF DEATH

05109

1

TO FUNERAL DIRECTOR AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residance before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick-Rural - Route 6
d. STREET ADDRESS: Bartonsville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: MAY — Last: Lare

4. DATE OF DEATH: Month: April — Day: 12, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 16 Dec 1879

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-work

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles H. Lare

14. MOTHER'S MAIDEN NAME: Annie Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Roy E. Lare, Route 1, Knoxville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO (b): Fractured Right hip — 1 week
DUE TO (c):

4500

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 10, 1962, to April 12, 1962, that (I) (we) last saw the deceased alive on April 11, 1962, and that death occured at 5 A.M, from the causes and on the date stated above.

22a. SIGNATURE: G W LeDan M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/12/62

22c. PHYSICIAN'S NAME (Type): G W LeDan

22d. ADDRESS: Boonsboro Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-14-62

23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery

23d. LOCATION (City, town or county) (State): Frederick, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Frank R. Etchison Jr.

M. R. Etchison & Son, Frederick, Maryland

25a. REC'D BY REGISTRAR DATE: APR 16 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1

FOR STATE HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05110

1. **PLACE OF DEATH**
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 62 MADISON AVENUE

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residance balora admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 62 MADISON AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JAMES — Middle FINDLAY — Last LITTLE

4. **DATE OF DEATH**: Month APRIL — Day 15 — Year 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 17 1896

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OWNER

10b. KIND OF BUSINESS OR INDUSTRY: COAL COMPANY

11. BIRTHPLACE (State or foreign country): WASHINGTON MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES A LITTLE

14. MOTHER'S MAIDEN NAME: SOPHIA FINDLAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES
(If yes give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. NANCY KNOWLES — Address: 200 E 66th STREET NEW YORK CITY

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, Descending Colon
153.2
DUE TO (b) Diastatic Perforation Of Ascending Colon With
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Acute Generalized Peritonitis.

INTERVAL BETWEEN ONSET AND DEATH: Recent

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4-20-62

EXAMINER'S NAME (Type): E.W.DITTO JR. M. D.

Address (Street, city, town, or county): 215 W WASHINGTON ST HAGERSTOWN MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4-18-62

22c. NAME OF CEMETERY OR CREMATORY: RIVERVIEW CEMETERY

22d. LOCATION (City, town, or country) (State): WILLIAMSPORT MARYLAND

23. FUNERAL DIRECTOR: Charles M Rouzer — ADDRESS: SUMMER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND

24a. REC'D BY REGISTRAR DATE: APR 23 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05113

CERTIFICATE OF DEATH

05111

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): GATEWAY NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 335 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLOTTE — Middle PAULINE — Last LONG

4. DATE OF DEATH: Month APRIL — Day 24 — Year 19 62

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 2/7/1894

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN H. GRIFFITH

14. MOTHER'S MAIDEN NAME: CATHERINE BURGUR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 229-09-7986

17. INFORMANT: MRS. MARGARET BATEMAN — Address: HAGERSTOWN MD.

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immed.
DUE TO
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b): General Arteriosclerosis and — 10 yrs
DUE TO
(c): Arteriosclerotic heart disease

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): Senility -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. — Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Aug 1, 1958 to Apr 24, 1962 that (I) (~~we~~) last saw the deceased alive on Apr 24 1962, and that death occured at 6:14 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward W. Ditto III M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/25/62
22c. PHYSICIAN'S NAME (Type): Edward W. Ditto, 111, M.D.
22d. ADDRESS: 217 W. Washington ST., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4/26/62
23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
23d. LOCATION (City, town or county) (State): HAGERSTOWN MD.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. J. Norment Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE APR 30 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05114

CERTIFICATE OF DEATH

05112

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Garlock Mem. Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 2112 Virginia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IDA Middle CATHERINE Last DELLINGER-LONG

4. DATE OF DEATH: Month April Day 22 Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jany 17 1878
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Downsville Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis Rhodes
14. MOTHER'S MAIDEN NAME: Sarah Forthman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Bertha Dellinger Address: Williamsport Md R # 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myelogenous leu Kemia — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO (b): 204.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Atherosclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 19 60 to April 22 19 62, that (I) (we) last saw the deceased alive on April 22 19 62 and that death occured at 2:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: M E Byrkit M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-24-62
22c. PHYSICIAN'S NAME (Type): M.E. Byrkit
22d. ADDRESS: Williamsport Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/25/62
23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
25a. REC'D BY REGISTRAR DATE: APR 26 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05115 (top) 05113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
   c. LENGTH OF STAY IN 1b: 40 YRS.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
   d. STREET ADDRESS: 116 MANSE RD.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: BERTHA — Middle: LOUISE — Last: MANN

4. **DATE OF DEATH**: Month: APRIL — Day: 25 — Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/20/1885

9. AGE (In years last birthday): 76 Yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN BREWER

14. MOTHER'S MAIDEN NAME: CATHERINE WINGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MR. CARL M. MANN — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis of abdomen — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

153.2

DUE TO (b): Carcinoma of Sternum colon — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 24 April, 1962, to 27 April, 1962, that (I) (we) last saw the deceased alive on 27 April 1962, and that death occured at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Elden S Hoadlander M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/27/62

22c. PHYSICIAN'S NAME (Type): Elden S Hoadlander

22d. ADDRESS: Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/28/62

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.

23d. LOCATION (City, town or county) (State): HAGERSTOWN MD.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. T. Norment, Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05116 05114

1. **PLACE OF DEATH**
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 48 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WESTERN MARYLAND STATE HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 923 MT. AETNA ROAD
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First LOTTIE Middle MANZELL Last MARKELL

4. **DATE OF DEATH**: Month APRIL Day 7 Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DECEMBER 29 1879

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME MAKER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM BOWERS

14. MOTHER'S MAIDEN NAME: IDA McCALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: WILLIAM C MARKELL HAGERSTOWN MARYLAND

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): LOBULAR PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

DUE TO (b): CARCINOMA OF BLADDER — 28 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ARTERIOSCLEROTIC HEART DISEASE. DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 2-19, 1962 to 4-7, 1962, that (I) (~~we~~) last saw the deceased alive on 4-7-1962, and that death occured at 11:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Antonio U. Pallagrosi M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ANTONIO U. PALLAGROSI

22d. ADDRESS: 1500 Pa Ave Hagerstown

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-11-62

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d. LOCATION (City, town or county) (State): HAGERSTOWN MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND

25a. REC'D BY REGISTRAR DATE: APR 10 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05117 05115

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. LENA - RURAL
   c. LENGTH OF STAY IN 1b: 14 YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BOONSBORO MD. R12

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. LENA - RURAL
   d. STREET ADDRESS: BOONSBORO MD. R. 2
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): CLARENCE (First) EDGAR (Middle) MARTIN (Last)

4. **DATE OF DEATH**: APRIL (Month) 16 (Day) 1962 (Year)

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: MAY. 21. 1896

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months 10 Days 25 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM

11. BIRTHPLACE (County & State, or foreign country): REID WASH. Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY J. MARTIN

14. MOTHER'S MAIDEN NAME: ANNIE CARPENTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): W.W. ONE

16. SOCIAL SECURITY NO.: WT-18-6608

17. INFORMANT: MRS. BEULAH I. MARTIN Address: BOONSBORO MD. R.2

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart with decompensation —
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 3, 1962, to April 16, 1962, that (I) (we) last saw the deceased alive on April 14 1962, and that death occured at 8 A.M., from the causes and on the date stated above.

22a. SIGNATURE: G. W. LeVan M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 4/16/62

22c. PHYSICIAN'S NAME (Type): G. W. LeVan

22d. ADDRESS: Boonsboro, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: APRIL 19. 1962

23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

23d. LOCATION (City, town or county) (State): BOONSBORO WASH. Co. MD.

24 FUNERAL DIRECTOR'S SIGNATURE: John A. Bard ADDRESS: BOONSBORO MD

25a. REC'D BY REGISTRAR DATE: APR 23 '62

25b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05118 05116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
   c. LENGTH OF STAY IN 1b: 55 YRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X HAGERSTOWN RURAL
   d. STREET ADDRESS: 1 HAGERSTOWN RT.#3
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First HERBERT — Middle WILLIAM — Last McELWEE

4. **DATE OF DEATH**: Month APRIL — Day 26 — Year 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 11/15/1887

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PREIDENT& OWNER

10b. KIND OF BUSINESS OR INDUSTRY: DAIRY PRODUCTS

11. BIRTHPLACE (County & State, or foreign country): CO. VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ISAAC R. McELWEE

14. MOTHER'S MAIDEN NAME: MARY BREWER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-30-9640

17. **INFORMANT**: MRS. RUTH B. McELWEE — Address RT. #3 HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary artery disease with angina — Indefinite

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20e. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 25 1941, to April 26 1962, that (I) (we) last saw the deceased alive on April 26 1962, and that death occured at 4:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: B B Kneisley M.D.

22b. DATE SIGNED: April 27, 1962

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.

22d. ADDRESS: 148 West Washington Street Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/29/62

23c. NAME OF CEMETERY OR CREMATORY: SMITHSBURG CEM.

23d. LOCATION (City, town or county) (State): SMITHSBURG MD.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. J. Norment, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05119 — Reg. Dist. No. 05117

1 FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 151 WEST WASHINGTON ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 151 WEST WASHINGTON ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle EDWARD Last MORRISON
4. DATE OF DEATH: Month APRIL Day 22 Year 1962
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCTOBER-10-1923
9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months 6 Days
IF UNDER 24 HRS.: Hours 12 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MECHANIC-
10b. KIND OF BUSINESS OR INDUSTRY: FARM IMPLEMENT CO.
11. BIRTHPLACE (State or foreign country): WASH. CO. MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRED N. MORRISON
14. MOTHER'S MAIDEN NAME: EDNA R. JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W. 2.
16. SOCIAL SECURITY NO.: 215-20-8942
17. INFORMANT: FRED N. MORRISON — Address: MIDDLEBORO MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxiation (By Smoke) — Interval between onset and death: Few minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9160
(b) 2nd. And 3rd. Degree Burns Involving Entire Body.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Found on bed, mattress completely burned.
20c. TIME OF INJURY: Hour 11 a. m. Month, Day, Year 4-22- 1962
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Hagerstown, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: April 24, 1962
EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: APRIL 25 1962
22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d. LOCATION (City, town, or county) (State): BOONSBORO WASH. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Bast — ADDRESS: BOONSBORO MD
24a. REC'D BY REGISTRAR DATE: APR 27 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05120 Items 8 & 9 Film G312 5/7/62 iwk

CERTIFICATE OF DEATH

05118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 800 Northern Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: HAMILTON — Last: MORROW

4. DATE OF DEATH: Month: April — Day: 10 — Year: 1962 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Dec 10 1894 / 1893

9. AGE (In years last birthday): 67 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State or foreign country): W. Va Summit Point Jefferson Co

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ruthvan W. Morrow

14. MOTHER'S MAIDEN NAME: Lillie M. Muse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes W.W. # 1

16. SOCIAL SECURITY NO.: 214-09-9634

17. INFORMANT — Address: Miss Josephene Morrow — Md. 800 Northern Ave Hagerstown

18. CAUSE OF DEATH [Enter one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Agranulocytic Leukemia — 1 year
204.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1962 to April 10, 1962 that (I) (we) last saw the deceased alive on April 10, 1962, and that death occured at 6:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: D. Ed Ditto M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 11, 1962

22c. PHYSICIAN'S NAME (Type): Dr. E.W. Ditto, Jr.

22d. ADDRESS: 215 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/13/62

23c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery

23d. LOCATION (City, town or county) (State): Shepherdstown W. Va. Jefferson 6

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 13 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05121

CERTIFICATE OF DEATH

05119

M

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be e[...]ed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 4 yrs - 1 mos.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Berkeley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Martinsburg — 85x-3
d. STREET ADDRESS: Route #3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) — First: Lillie — Middle: E. — Last: Myers

4. DATE OF DEATH — Month: April — Day: 12 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: February 27 1873 (corrected; original entry struck out)
9. AGE (In years last birthday): 89
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Duties
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Berkley Co., W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Jacob T McQuilkin
14. MOTHER'S MAIDEN NAME: Ellen Whiting

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: J. Howard Myers, son — Address: Charleston, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

	Cause	Interval between onset and death
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial infarction	10 hrs
DUE TO (b)	Generalized Atherosclerosis	20 yrs
DUE TO (c)		

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March, 1961, to April 12, 1962, that (I) (we) last saw the deceased alive on April 12, 1962, and that death occured at 7 P.M, from the causes and on the date stated above.

22a. SIGNATURE: M E Bykit, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-12-62
22c. PHYSICIAN'S NAME (Type): M.E. By-Kit
22d. ADDRESS: Williamsport Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-14-1962
23c. NAME OF CEMETERY OR CREMATORY: Rosedale Cemetery
23d. LOCATION (City, town or county) (State): Martinsburg, West Va.

24. FUNERAL DIRECTOR'S SIGNATURE: H. K. Brown — ADDRESS: Martinsburg, W. Va.
25a. REC'D BY REGISTRAR DATE: APR 16 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kerns

VR A15 (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05122

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05120

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 11 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 805 Dewey Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROBERT — Middle: JEREMIAH — Last: PEDDICORD

4. DATE OF DEATH: Month: April — Day: 11, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: May 2, 1916

9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland,

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Walter D. Peddicord

14. MOTHER'S MAIDEN NAME: Goldie D. Somerville

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): W.W. 2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joseph D. Peddicord, 1312 Hamilton Blvd
Address: Hagerstown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolization; Left Massive
DUE TO Acute Subdural Hematoma, Right Hemisphere
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Contusions Of Right Cerebral Hemisphere
DUE TO Hemorrhagic Necrosis With Cyst Formation Right
(c) Temporal Lobe.

INTERVAL BETWEEN ONSET AND DEATH: 10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Do not know. Brought into Emergency Room semi- conscious.

20c. TIME OF INJURY Hour: 1 p.m. — Month, Day, Year: 4-1- 19 62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Jail Alley.

20f. (City or town): Hagerstown, (County): Washington, (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: E. W. Ditto Jr. M.D.

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: April 12, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/14/62

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or country): Hagerstown, (State): Wash. Co. Md.

23. FUNERAL DIRECTOR — ADDRESS: Andrew K. Coffman Hagerstown, Maryland.

24a. REC'D BY REGISTRAR DATE: APR 19 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Hawn

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05123

CERTIFICATE OF DEATH

Reg. Dist. No. 05121

1. PLACE OF DEATH
a. COUNTY: Wash. — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Pa. b. COUNTY: Franklin

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Hagerstown
c. LENGTH OF STAY IN 1b: 2 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greencastle, Pa. 75X·3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gateway Nursing Home

d. STREET ADDRESS: 241 S. Allison ST

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mae Middle: J. Last: Pentz

4. DATE OF DEATH: Month: April Day: 15 Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 11, 1874

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Huntingdon Co, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas McKelvey

14. MOTHER'S MAIDEN NAME: Alice Hicks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Stanley Pentz Address: Greencastle, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Breast. — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
170X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr. 12, 1962 to Apr. 15, 1962 that I last saw the deceased alive on Apr. 14, 1962, and that death occurred at 9 A M, from the causes and an the date stated above.

ACTUAL SIGNATURE: David R. Brewer M.D. ADDRESS (Street, city or town, state): Clear Spring Md DATE SIGNED: 4/17/62

PHYSICIAN'S NAME (Type): David R. Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b. DATE THEREOF: 4/18/62

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Greencastle, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: A.E. Wenrich ADDRESS: Greencastle, Pa.

24a. REC'D BY REGISTRAR DATE: APR 19 '62

24b. REGISTRAR'S SIGNATURE: Evelyn R. Hann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05124

CERTIFICATE OF DEATH

05122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M 90 I 0 1

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
   c. LENGTH OF STAY IN 1b: 6 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Gateway Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hagerstown
   d. STREET ADDRESS: 417 Brewer Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Edward — Middle: — Last: Porter

4. **DATE OF DEATH**: Month: April — Day: 22 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 18, 1881

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Iron works

10b. KIND OF BUSINESS OR INDUSTRY: Metal worker

11. BIRTHPLACE (County & State, or foreign country): Bendersville Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Elmer Porter

14. MOTHER'S MAIDEN NAME: Catherine Petrs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-10-3283A

17. **INFORMANT**: Mrs. Virginia A. Syncire — Address: 417 Brewer Ave. Hagerstown, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterio Sclerotic Heart Dis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar. 1, 1962 to April 22, 1962, that (I) (we) last saw the deceased alive on April 21, 1962, and that death occured at 3:30 M, from the causes and on the date stated above.

22a. SIGNATURE: David R. Brewer M.D. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/23/62

22c. PHYSICIAN'S NAME (Type): David R. Brewer

22d. ADDRESS: Clear Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/25/62

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 26 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Wm. G. Horst

VR A1S (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05125

CERTIFICATE OF DEATH

05123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 45 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
   d. STREET ADDRESS: 19 W. Magnolia Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Mary — Middle: Cassandra — Last: Potterfield

4. **DATE OF DEATH**: Month: April — Day: 5 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 30, 1911

9. AGE (In years last birthday): 50 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Waynesboro, Pa.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Sidney Ellis

14. MOTHER'S MAIDEN NAME: Lulu Forney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: 214-09-2764

17. INFORMANT: Charles Potterfield — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Subarachnoid hemorrhage	39 hours
DUE TO (b)	Rupture of aneurysm of left vertebral artery	39 hours
DUE TO (c)		

330X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~XXXXXX~~) attended the deceased from Apr. 3, 1962, to Apr. 5, 1962, that (I) (We) last saw the deceased alive on Apr. 5 1962 2:45 pm, and that death occured at ... M, from the causes and on the date stated above.

22a. SIGNATURE: W. Layman M.D. — M.D.

22b. DATE SIGNED: 4-6-62

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): William T. Layman, M.D.

22d. ADDRESS: 5 Public Square, Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-8-62

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son Hagerstown, Md.

25a. REC'D BY REGISTRAR — DATE: APR 9 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05126

CERTIFICATE OF DEATH

05124

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 6 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 [illegible] FRANKLIN [illegible] HAGERSTOWN MD
d. STREET ADDRESS: 919 W FRANKLIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOROTHY — Middle MARIE — Last RAIFSNIDER

4. DATE OF DEATH: Month APRIL — Day 30 — Year 19 62

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: JULY 6 1900

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESCLERK

10b. KIND OF BUSINESS OR INDUSTRY: DEP'T STORE

11. BIRTHPLACE (County & State, or foreign country): MANSFIELD OHIO

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: MILFORD J BOUGHTON

14. MOTHER'S MAIDEN NAME: EDNA BELL ROGERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 217-10-3270

17. INFORMANT — Address: HARVEY E RAIFSNIDER HAGERSTOWN MARYLAND

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Carcinoma Cervix
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 [illegible] / 10 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma Breast

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY — Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 16 March 1962 to 30 April 1962 that (I) (we) last saw the deceased alive on 30 April 1962 and that death occured at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1 May 62

22c. PHYSICIAN'S NAME (Type): FRANK E BRUMBACK M. D.

22d. ADDRESS: 170 W WASHINGTON ST. HAGERSTOWN MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-2-62

23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY

23d. LOCATION (City, town or county) (State): HAGERSTOWN MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: [signature]

ADDRESS: SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND

25a. REC'D BY REGISTRAR DATE: MAY 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05127

CERTIFICATE OF DEATH

05125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
   c. LENGTH OF STAY IN 1b: 3 HOURS
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WASH. Co. HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: WASHINGTON
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): X APPLETOWN (RURAL)
   d. STREET ADDRESS: BOONSBORO MD. R.2
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: DANI — Middle: DIANE — Last: REED

4. **DATE OF DEATH**: Month: APRIL — Day: 15. — Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST. 20. 1958

9. AGE (In years last birthday): 3 yrs. — IF UNDER 1 YEAR: Months: 7 — Days: 25 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): WASH. Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DANIEL REED

14. MOTHER'S MAIDEN NAME: ELAINE DE WITT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: DANIEL REED BOONSBORO MD. R.2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

744.0

IMMEDIATE CAUSE (a): Acute Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Bilateral basal pneumonia — 24 hours.

DUE TO (c): Mycoplasma pneumonia — 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April, 1961, to 4/15, 1962, that (I) (we) last saw the deceased alive on 4/15, 1962, and that death occured at 3:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: George Jennings M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4/17/62

22c. PHYSICIAN'S NAME (Type): George Jennings — 22d. ADDRESS: 136 W. Washington St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: APRIL-18-1962 — 23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY — 23d. LOCATION (City, town or county) (State): BOONSBORO WASH. Co. MD

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast — ADDRESS: BOONSBORO MD.

25a. REC'D BY REGISTRAR DATE: APR 23 '62 — 25b. REGISTRAR'S SIGNATURE: Clinton S. Frame

VR A15 (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05128

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05126

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME 5M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Cty, Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1369 Marshall St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lelia; Middle: Caroline; Last: Reigh

4. DATE OF DEATH: Month: April; Day: 15; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 2, 1925

9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Stouffer's Rest.

11. BIRTHPLACE (State or foreign country): St James Wash Co Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Luther Wine

14. MOTHER'S MAIDEN NAME: Anna Lee Gochenour

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service): --

16. SOCIAL SECURITY NO.: 216-20-9879

17. INFORMANT Address: Donald Reigh, 1369 Marshall St Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Comminuted Basilar Skull Fracture — INTERVAL BETWEEN ONSET AND DEATH: 12 days
DUE TO: Compounded Through Cribriform Plate & Ethmoid Sinus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Lepto Meningitis Acute
DUE TO (c): Cerebral Congestion & Edema

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in Taxi that collided with a truck.

20c. TIME OF INJURY: Hour e.m.: 7:45 — Month, Day, Year: 4-3- 1962

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town): Hagerstown (County): Washington (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: I. E. Ditto M.D.

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: April 16, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/17/62

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or country) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR ADDRESS: Andrew K. Coffman, Hagerstown, Md.

24c. RECD BY REGISTRAR DATE: APR 18 62

24b. REGISTRAR'S SIGNATURE: Clifford L. Keefer

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05129

CERTIFICATE OF DEATH

05127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: ~~Garrett~~ Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 9 Months
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ~~XXXXXXX~~ Western Maryland State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Pr, George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Temple Hills, Maryland 1617-2
   d. STREET ADDRESS: 5545- Selby Lane S.E.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAURA — Middle ALICE — Last RICHARDS

4. DATE OF DEATH: Month APRIL — Day 6 — Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 3rd 1901

9. AGE (In years last birthday): 60 yrs.
   IF UNDER 1 YEAR: Months ___ Days ___
   IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): Richmond, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H. Whittaker

14. MOTHER'S MAIDEN NAME: Laura Whittaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Pauline L. Poole — Address: Same as # 2. Dau.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), end (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: FEW MINUTES

4-20-1

DUE TO (b): ___

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): RHEUMATOID ARTHRITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 7-18-, 1961, to 4-6-, 1962 that (I) ~~(we)~~ last saw the deceased alive on 4-6-, 1962, and that death occured at 11:45 M, from the causes and on the date stated above.

22a. SIGNATURE: Antonio U. Pellagrosi, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ANTONIO U. PALLAGROSI

22d. ADDRESS: 1500 Pa Ave Hagerstown

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aprilk 11th 62

23c. NAME OF CEMETERY OR CREMATORY: St. Barnabas Cemetery

23d. LOCATION (City, town or county) (State): Oxon Hill, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros — ADDRESS: 1661- Good Hope Rd. SE Washington, DC

25a. REC'D BY REGISTRAR DATE APR 9 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05130

CERTIFICATE OF DEATH

Item 23c FilmG311 4/13/62 iwk

05128

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Weverton
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): —

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Weverton
   d. STREET ADDRESS: —
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Annie; Middle: O.; Last: Rickords

4. **DATE OF DEATH**: Month: 4; Day: 6; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-18-1880

9. AGE (In years last birthday): 81 yrs.
   IF UNDER 1 YEAR: Months | Days
   IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joshua Ohler

14. MOTHER'S MAIDEN NAME: Sarah Crouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mrs. Edith Kelbaugh, Knoxville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Edema	2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Myocardial Decompensation	3 mo
422.1 DUE TO (c)	Advanced Cardio Vascular Disease	5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Nephritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 4, 1962 To April 6, 1962 that (I) (we) last saw the deceased alive on April 4 1962 and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: A. T. Brice — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): A. T. BRICE

22d. ADDRESS: Jefferson Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-8-1962

23c. NAME OF CEMETERY OR CREMATORY: St. Luke's Episcopal Cem. Brothers Brownsville Heights

23d. LOCATION (City, town or county) (State): Brownsville, Md

24 FUNERAL DIRECTOR'S SIGNATURE: C. W. Fields

ADDRESS: Brunswick, Maryland

25a. REC'D BY REGISTRAR DATE: APR 10 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05131

CERTIFICATE OF DEATH

05129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
   c. LENGTH OF STAY IN 1b: 70 YRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 308 N. CANNON AVE.

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
   d. STREET ADDRESS: 330 N. MULBERRY ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: MARGARET — Middle: LORETTA — Last: ROHRER

4. **DATE OF DEATH**: Month: APRIL — Day: 18 — Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/2/1880

9. AGE (In years last birthday): 81 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN LONG

14. MOTHER'S MAIDEN NAME: ELIZABETH BARTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

16. SOCIAL SECURITY NO.: 220-28-8872

17. INFORMANT: MR. WILLIAM H. ROHRER — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

4508

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture Colles, right of about six weeks duration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 2-21-61

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from mm mm mm, 19..., to death, 19..., that (I) (we) last saw the deceased alive on 4-17-62, and that death occured at 2:10 PM from the causes and on the date stated above.

22a. SIGNATURE: Robert F. Keadle — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-19-62

22c. PHYSICIAN'S NAME (Type): Paul Harrison by Robert F. KEadle

22d. ADDRESS: Hagerstown Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4/20/62
23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
23d. LOCATION (City, town or county) (State): HAGERSTOWN MD.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. J. Norment, Hagerstown, Md.

25a. REC'D BY REGISTRAR — DATE: APR 23 '62

25b. REGISTRAR'S SIGNATURE: Clarence L. Kreitz

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05132

CERTIFICATE OF DEATH

Reg. Dist. No. 05130

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 years in
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co., Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Evelyn — Middle — Last Rosenberry

4. DATE OF DEATH: Month April — Day 16 — Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 25, 1927

9. AGE (In years last birthday): 34 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Central City, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles William Deneen

14. MOTHER'S MAIDEN NAME: Bertha Mae Kirchner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Bertha Logsdon Hyndman, Pa. RD#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastro intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Cerebral Thrombosis — years
DUE TO (c): Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

581.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1962, to April, 1962, that I last saw the deceased alive on April 15, 1962, and that death occurred at 1:54 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Elden C Hoachlander M.D. — ADDRESS (Street, city or town, state): 115 W. Main St — DATE SIGNED: 4/16/62

PHYSICIAN'S NAME (Type): Elden C Hoachlander — Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 19, 1962

22c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery

22d. LOCATION (City, town, or county) (State): Hyndman, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Ziegler — ADDRESS: Hyndman, Pa.

24a. REC'D BY REGISTRAR — DATE: APR 19 '62

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 must be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05133 — Item 8 Film G311 4/25/62 mh — 05131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

1. PLACE OF DEATH a. COUNTY: WASHINGTON — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN c. LENGTH OF STAY IN 1b: 10 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL	d. STREET ADDRESS: 423 N. MULBERRY ST. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MARY	ANN	SAMPSELL	APRIL	17	19 62

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	WHITE		7/17/1896	65 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HARVEY MYERS	ANNIE WOLF

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	NONE	MR. REGINALD F. SAMPSELL	HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Collapse — INTERVAL BETWEEN ONSET AND DEATH: DNK

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Cerebral vascular accident

DUE TO (c) Arteriosclerosis Gen.

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 29, 19 62, to Apr 17, 19 62, that (I) (~~this~~) last saw the deceased alive on Apr 15, 19 62, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Louis S Graff M.D.		4/19/62
22c. PHYSICIAN'S NAME (Type) LOUIS GRAFF	22d. ADDRESS 119 E. Antietam	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	4/19/62	BROADFORDING CHURCH	WASHINGTON CO. MD.

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W. J. Norment, Hagerstown, Md		APR 23 '62	Arthur L. Harris

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05134 05132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 710 W. WASHINGTON ST.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 710 W. WASHINGTON ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle JOHN Last SCHMIDT

4. DATE OF DEATH: Month APRIL Day 5 Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 5/30/1874

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED ANTIQUE DEALER

10b. KIND OF BUSINESS OR INDUSTRY: OWN BUSINESS

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GOTTLIEB SCHMIDT

14. MOTHER'S MAIDEN NAME: SUSAN ANN MAISACK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. HELEN JOHNSON Address: HAGERSTOWN MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): gen'l arteriosclerosis
DUE TO (b): 4502
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: abt. 1yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ON 4/5/62, 19 at 11:30 P.M. 19, that (I) (we) last saw the deceased alive on 19 and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Howard M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/6/62

22c. PHYSICIAN'S NAME (Type): Howard N. Weeks, M. D.

22d. ADDRESS: 136 N. Potomac Street

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/8/62

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.

23d. LOCATION (City, town or county) (State): HAGERSTOWN MD.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. J. Norment, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 10 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

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FOR STATE HEALTH DEPT.

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TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05135 05133

1. PLACE OF DEATH
a. COUNTY: WASHINGTON MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL WEVERTON
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ROUTE 340 WEVERTON

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FUNKSTOWN
d. STREET ADDRESS: 101 EAST MAPLE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: BILLY Middle: WELLINGTON Last: SHEPLEY

4. DATE OF DEATH — Month: APRIL Day: 15 Year: 1962

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 11 1917
9. AGE (In years last birthday): 44 yrs. IF UNDER 1 YEAR Months / Days IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSPECTOR
10b. KIND OF BUSINESS OR INDUSTRY: STATE ROAD COMM.
11. BIRTHPLACE (State or foreign country): HAGERSTOWN, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILBUR WELLINGTON SHEPLEY
14. MOTHER'S MAIDEN NAME: MAMIE GOUKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 21710 3017
17. INFORMANT: SHIRLEY M. SHEPLEY Address: 101 EAST MAPLE STREET FUNKSTOWN, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thrombotic Occlusions, Anterior Descending And Right Coronary Arteries — INTERVAL BETWEEN ONSET AND DEATH: Recent

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Myocardial Infarction, Left Ventricle, Old And Recent
DUE TO (c) Pulmonary Edema

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4-20-62
EXAMINER'S NAME (Type): E.W.DITTO JR. M. D.
Address (Street, city, town, or county): 215 W Washington St HAGERSTOWN MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: APRIL 21 1962
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY
22d. LOCATION (City, town, or country) (State): HAGERSTOWN MARYLAND

23. FUNERAL DIRECTOR: SUTER-ROUZER Address: 305 NORTH POTOMAC STREET HAGERSTOWN MARYLAND
24a. REC'D BY REGISTRAR DATE: APR 23 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

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FOR STATE HEALTH DEPT.

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TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05136

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05134

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): PARAMOUNT (RURAL)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): HAGERSTOWN RD#6 (Died on arrival Hagerstown Hospital)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PARAMOUNT X HAGERSTOWN RD#6
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH Middle M. Last SHUCK
4. DATE OF DEATH: Month APRIL Day 23 Year 1962

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN 14. 1888
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School TEACHER
10b. KIND OF BUSINESS OR INDUSTRY: SCHOOLS
11. BIRTHPLACE (State or foreign country): FRANKLIN Co. PA
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: HARMON L SHUCK
14. MOTHER'S MAIDEN NAME: MARY M. BURKETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 219-36-3798
17. INFORMANT: Mrs Mary Shuck Address: Hagerstown, Md RD # 6

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombotic Occlusion, Anterior Descending Branch
DUE TO: Of Left Coronary Artery, Recent
INTERVAL BETWEEN ONSET AND DEATH: Recent

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Atherosclerosis, Generalized
DUE TO (c): Diabetes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell down cellar steps at his home.
20c. TIME OF INJURY Hour 12:50 p.m. Month, Day, Year 4-23- 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Hagerstown R# 6, (County) Washington, (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: April 24, 1962
EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: April 25/1962
22c. NAME OF CEMETERY OR CREMATORY: Beautiful View
22d. LOCATION (City, town, or country): State Line (State) Md

23. FUNERAL DIRECTOR: A.E. Minnich ADDRESS: Greencastle Pa
24a. REC'D BY REGISTRAR DATE APR 26 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kuhns

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05137

CERTIFICATE OF DEATH

05135

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 55 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 104 E. First St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 104 E. First St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Charles — Middle: Henry — Last: Smith

4. **DATE OF DEATH**: Month: April — Day: 8 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 28, 1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10b. KIND OF BUSINESS OR INDUSTRY: Shoe Factory

11. BIRTHPLACE (County & State, or foreign country): Martinsburg, W. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Phillip Smith

14. MOTHER'S MAIDEN NAME: Sarah Jane Henry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: 214-09-5467a

17. INFORMANT — Address: Mrs. Velda Grimes Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 week
420.0
DUE TO (b): Atherosclerotic Heart Disease — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma of Prostate, suspected.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~XXXXXX~~) attended the deceased from Apr. 1, 1962, to Apr. 8, 1962, that (I) (We) last saw the deceased alive on Apr. 7, 1962 6:15 pm, and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: Wm T Layman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-9-62

22c. PHYSICIAN'S NAME (Type): William T. Layman, M.D.

22d. ADDRESS: 5 Public Square Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr. 10, 62

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son Hagerstown, Md.

25a. REC'D BY REGISTRAR — DATE: APR 11 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be e... within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05138 05136

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md.
   c. LENGTH OF STAY IN 1b: 38 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown Maryland
   d. STREET ADDRESS: 340 Blooms Court
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Jack — Middle: (no) — Last: Stokes

4. **DATE OF DEATH**: Month: April — Day: 17 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 24 1900

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Concrete Works

11. BIRTHPLACE (County & State, or foreign country): Williamston, N.C

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Thomas Stokes

14. MOTHER'S MAIDEN NAME: Winnie Spruill — 5456 16th Ave Newark, N.J.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: 579-07-7453

17. INFORMANT: Miss Fannie Stokes — 5456 16th. Ave Newark, N.J.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRO-VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 10-12 DAYS

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): HYPERTENSIVE CARDIO-VASCULAR DISEASE. — UNKNOWN

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): (1) DIABETES MELLITUS (2) UREMIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 6, 1962, to April 17, 1962, that (I) (we) last saw the deceased alive on 17 April 1962, and that death occured at 4:05 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Wm. Noel Fender M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 20 April 1962

22c. PHYSICIAN'S NAME (Type): Wm. Noel Fender, M. D.

22d. ADDRESS: 218 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-23-1962

23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows Cemetery

23d. LOCATION (City, town or county) (State): Williamston, N.C

24 FUNERAL DIRECTOR'S SIGNATURE: John R Watson Jr Vagenturin Md

ADDRESS

25a. REC'D BY REGISTRAR DATE: APR 23 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05139 05137

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
   c. LENGTH OF STAY IN 1b: 3 WEEKS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH. Co. HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND. b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL (WOLFSVILLE RD)
   d. STREET ADDRESS: BOONSBORO MD. R.2
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: DELLA Middle: B Last: STONEBERGER

4. **DATE OF DEATH**: Month: APRIL Day: 15. Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY 17-1899

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months: 1 Days: 28

IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): STANLEY VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES ALSHIRE

14. MOTHER'S MAIDEN NAME: HESTER (NO RECORD)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: HARRY W. STONEBERGER SR. Address: BOONSBORO MD R.2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Thyroid Storm — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

252.0

DUE TO (b): Grave's Disease — Years —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive Heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2De. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1950, to April 15, 1962, that (I) (we) last saw the deceased alive on April 14 1962, and that death occured 4 P.M., from the causes and on the date stated above.

22a. SIGNATURE: J Secondari M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDARI

22d. ADDRESS BOONSBORO Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: APRIL 18 1962

23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

23d. LOCATION (City, town or county) (State): BOONSBORO WASH. Co. MD.

24 FUNERAL DIRECTOR'S SIGNATURE: John H. Bast ADDRESS: BOONSBORO MD

25a. REC'D BY REGISTRAR DATE APR 23 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05140

CERTIFICATE OF DEATH

05138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Williamsport
   c. LENGTH OF STAY IN 1b: 8mos. 1½mos.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Williamsport Sanitarium

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Pennsylavania — b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
   d. STREET ADDRESS: 235 W. Second St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Nettie — Middle — Last: Warnick

4. **DATE OF DEATH**: Month: April — Day: 14 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: August 10, 1869

9. AGE (In years last birthday): 92 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Willow Hill, Pennsylavania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William W. ~~Stringer~~ Stinger

14. MOTHER'S MAIDEN NAME: Elizabeth Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: Mr. Clyde Warnick 231 W. Second St Waynesboro, PA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b): Diabetis Mellitis — 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerosis + Myocardiatis — 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 19 61 to 4/14 19 62, That (I) (we) last saw the deceased alive on 4/14 19 62 and that death occured at 6:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. B. Brown M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): R. B. Brown M.D.

22d. ADDRESS: Waynesboro Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/17/62

23c. NAME OF CEMETERY OR CREMATORY: Green Hill

23d. LOCATION (City, town or county) (State): Waynesboro, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE: Walter Y Gore — ADDRESS: Waynesboro, Penna

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kline

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05139

1. PLACE OF DEATH
a. COUNTY: Washington County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: W.Va. — b. COUNTY: Morgan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sleepy Creek 85 x 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Isaac s — Middle: Ray — Last: Watson

4. DATE OF DEATH: Month: April — Day: 7, — Year: 1962

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	White	NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	2/4/62	yrs.	2	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	North Carolina	U.S.

13. FATHER'S NAME: Julius H. Watson

14. MOTHER'S MAIDEN NAME: Juanita K. Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
no	none	Juanita K. Watson Sleepy Creek

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Interstitial Pneumonia	20 hours
DUE TO (b)		
DUE TO (c)		

492X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: E. W. Ditto Jr. M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 4-7-62

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	4/10/62	Shriver's Cemetery	Morgan County, W.Va.

23. FUNERAL DIRECTOR — ADDRESS	24a. REC'D BY REGISTRAR — DATE	24b. REGISTRAR'S SIGNATURE
Howard F. Hovse Hancock Md	APR 10 '62	Arthur S. Krause

2170

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05142 **CERTIFICATE OF DEATH** 05140

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Washington
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
   c. LENGTH OF STAY IN 1b: 6½ years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Williamsport Sanitarium

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Towsbleburg 03X-2
   d. STREET ADDRESS: Old Hanover Road.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: Elva Middle: Cedonia Last: Watts

4. **DATE OF DEATH**: Month: April Day: 27 Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: July 28, 1869

9. AGE (In years last birthday): 92 yrs.
   IF UNDER 1 YEAR: Months: Days:
   IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Hamstein Carroll Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: B. Jackson

14. MOTHER'S MAIDEN NAME: S. B. Benson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Mayme Bange Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/27/62 to 4/27/62 that (I) (we) last saw the deceased alive on 4/27/62, and that death occured at 12:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Ralph Young M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/27/62

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/29/62

23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove Cem.

23d. LOCATION (City, town or county) (State): Balto. Co. Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: H. J. Eckhardt ADDRESS: Owings Mills, Maryland

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Dr. Superintendent Signature

Principal Signature 4/27/65 4/27/65 4/27/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05143

CERTIFICATE OF DEATH

05141

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1212 Glenwood Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HARRY — Middle: EARL — Last: WEAGLEY SR.

4. DATE OF DEATH: Month: April — Day: 24, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: May 26, 1892

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Rouzersville, Pennsylvania.

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: William Weagley

14. MOTHER'S MAIDEN NAME: Ida Kinsel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give war or dates of service): ----- 217-10-3455

17. INFORMANT: Florence M. Sheaffer, 600½ Guilford Ave. Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Nonfunctioning kidney, right; stag-horn calculus right kidney — Indefinite

DUE TO

(c) Anemia secondary — Indefinite

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Advanced chronic osteitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 6, 19 62 to April 24, 19 62, that ~~(I)~~ (we) last saw the deceased alive on April 24 19 62, and that death occured at 1 PM, from the causes and on the date stated above.

22a. SIGNATURE: B. B. Kneisley M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/25/62

22c. PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.

22d. ADDRESS: 148 West Washington Street Hagerstown Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/27/62

23c. NAME OF CEMETERY OR CREMATORY: Weltys Cemetery

23d. LOCATION (City, town or county) (State): GREENSBURG, Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman

ADDRESS: Hagerstown, Maryland

25a. REC'D BY REGISTRAR DATE: APR 26 '62

25b. REGISTRAR'S SIGNATURE: Clifton L. Hamm

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death.

VR A15 (4)
1SM 7/61

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05144 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05142

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 22 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 48 McKee Ave

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 48 McKee Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HERMAN Middle DAVID Last WEEKS Sr
4. DATE OF DEATH: Month April Day 28 Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 15 1901
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Branch Manager
10b. KIND OF BUSINESS OR INDUSTRY: Sealtest Foods
11. BIRTHPLACE (State or foreign country): So Car. Lone Star Calhoun Co
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Daniel Weeks
14. MOTHER'S MAIDEN NAME: Rowena Zeagler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: 214-09-8556
17. INFORMANT Address: Mrs Beatrice A. Weeks 48 McKee Ave Hagerstown Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Compound Occipital Skull Fracture
DUE TO: Cerebral Contusion, Rt. Frontal And Occipital
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Lobes
DUE TO: Subarrachnoid Hemorrhage
(c) Aspiration Of Vomitus
900.0

INTERVAL BETWEEN ONSET AND DEATH: Recent

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell backwards down stairsteps at his home.
20c. TIME OF INJURY Hour 10:30 p.m. Month, Day, Year 4-28-62 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Hagerstown, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: April 30, 1962
EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/1/62
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or country) (State): Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: MAY 2 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05145

CERTIFICATE OF DEATH

05143

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X rural Smithsburg
d. STREET ADDRESS: 1 RFD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Lydia — Middle Elizabeth — Last Wiles

4. DATE OF DEATH: Month 4 — Day 22 — Year 1962

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Aug. 6, 1882

9. AGE (In years last birthdey): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Frederick, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Christian Gerlach

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Roy L. Wiles, RFD 2, Smithsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 592 X

DUE TO (b): Chronic Nephritis — 5 years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 22, 19 53 to April 22 19 62 that (I) ~~(we)~~ last saw the deceased alive on April 22 19 62 and that death occured at 6:05 A M, from the causes and on the date stated above.

22a. SIGNATURE: Young E. Chun M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: April 22 1962

22c. PHYSICIAN'S NAME (Type): YOUNG E. CHUN

22d. ADDRESS: 1500 penna. Ave. Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 4-24-62

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.

25a. REC'D BY REGISTRAR DATE APR 26 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Thrasher

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05146

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05144

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 wks.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Co, Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 601 W. Franklin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JEFFERIES — Middle ALLEN — Last WILLIAMS

4. DATE OF DEATH: Month April — Day 3, — Year 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 31, 1911

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aircraft Machanic

10b. KIND OF BUSINESS OR INDUSTRY: Fairchild Aircraft. Corp.

11. BIRTHPLACE (State or foreign country): Meridian, Mississippi.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Claude Williams

14. MOTHER'S MAIDEN NAME: Ruby Dowdle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Margaret Williams, 601 W. Franklin St. — Address: Hagerstown, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis following gunshot — INTERVAL BETWEEN ONSET AND DEATH: 13 days
DUE TO
(b): wounds (6) of abdomen
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Uremia & Pneumonitis — 12 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Shot in abdomen

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 3-19 1962

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Hagerstown (County) Washington (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): [illegible]

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 4/3/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/6/62

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or country) (State): Hagerstown Wash. Co. Md.

23. FUNERAL DIRECTOR — ADDRESS: Andrew K. Coffman, Hagerstown, Maryland

24a. REC'D BY REGISTRAR — DATE: APR 9 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05147 05145

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

M 81 I 8 1

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
   d. STREET ADDRESS: 1 200 Taylor Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Sadie — Middle: Blanche — Last: Wolfe

4. **DATE OF DEATH**: Month: April — Day: 2 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 7, 1884

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Bakersville, Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John L. Davis

14. MOTHER'S MAIDEN NAME: Mary Ellen Sellers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. J. E. Pleasant — Address: R# 4 Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

24 hrs

DUE TO (b): Acute Congestive Heart Failure — 5-6 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Bronchial Asthma — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive Cardio-Vascular Disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on 4/2/1962, and that death occured at 2:40 AM, from the causes and on the date stated above.

22a. SIGNATURE: Wm. Noel Fender M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/2/62

22c. PHYSICIAN'S NAME (Type): Wm. Noel Fender, M. D.

22d. ADDRESS: 218 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/4/62 — 23c. NAME OF CEMETERY OR CREMATORY: Funkstown Cemetery — 23d. LOCATION (City, town or county) (State): Funkstown Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Wm. G. Horst — ADDRESS: Rest Haven Funeral Chapel Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 5 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kline

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05148

CERTIFICATE OF DEATH

05146

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 5 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
   d. STREET ADDRESS: 901 Oak Hill Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: RUSSELL — Middle: BOSTETTER — Last: YOUNG

4. **DATE OF DEATH**: Month: April — Day: 14 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 21 1895

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10b. KIND OF BUSINESS OR INDUSTRY: Own Properties

11. BIRTHPLACE (County & State, or foreign country): Funkstown Wash Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph A. Young Sr.

14. MOTHER'S MAIDEN NAME: Mary Bostetter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes W.W.# 1

16. SOCIAL SECURITY NO.: 219-36-4624

17. INFORMANT — Address: John B. Young 1141 Hamilton Blvd Hagerstown Mdd

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarction	4 days
DUE TO (b)	Coronary Thrombosis	4 days
DUE TO (c)		

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this~~ hospital) attended the deceased from April 10, 1962 to April 14, 1962 that (I) (~~we~~) last saw the deceased alive on April 14 1962, and that death occured at 6:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Lloyd A. Hoffman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/16/62

22c. PHYSICIAN'S NAME (Type): Lloyd A. Hoffman

22d. ADDRESS: 214 N. Potomac St. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/17/62

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05149 05147

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 866 Dewey Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Knode — Last: Zeller Sr.

4. DATE OF DEATH: Month: April — Day: 18 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 31, 1879

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor & Builder

10b. KIND OF BUSINESS OR INDUSTRY: Houses

11. BIRTHPLACE (County & State, or foreign country): Mt. Morris, Ill.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph H. Zeller

14. MOTHER'S MAIDEN NAME: Laura Ann Knode

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)

16. SOCIAL SECURITY NO.: 214-34-0002

17. INFORMANT — Address: Mrs. H. K. Zeller 866 Dewey Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 8 mo.

157 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Oct 6, 1961, to April 18, 1962 that (I) (~~we~~) last saw the deceased alive on April 18 1962, and that death occured at 8:30 A.M. from the causes and on the date stated above.

22e. SIGNATURE: Lloyd A. Hoffman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/19/62

22c. PHYSICIAN'S NAME (Type): Lloyd A. Hoffman

22d. ADDRESS: 214 N. Potomac st. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/20/62

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or County) (State): Hagerstown Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 23 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Wm. C. Hoist

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61